

SECTION

11

Other services

Dialysis

Hospice

Clinical laboratory

Chart 11-1. Number of dialysis facilities is growing, and share of for-profit and freestanding dialysis providers is increasing

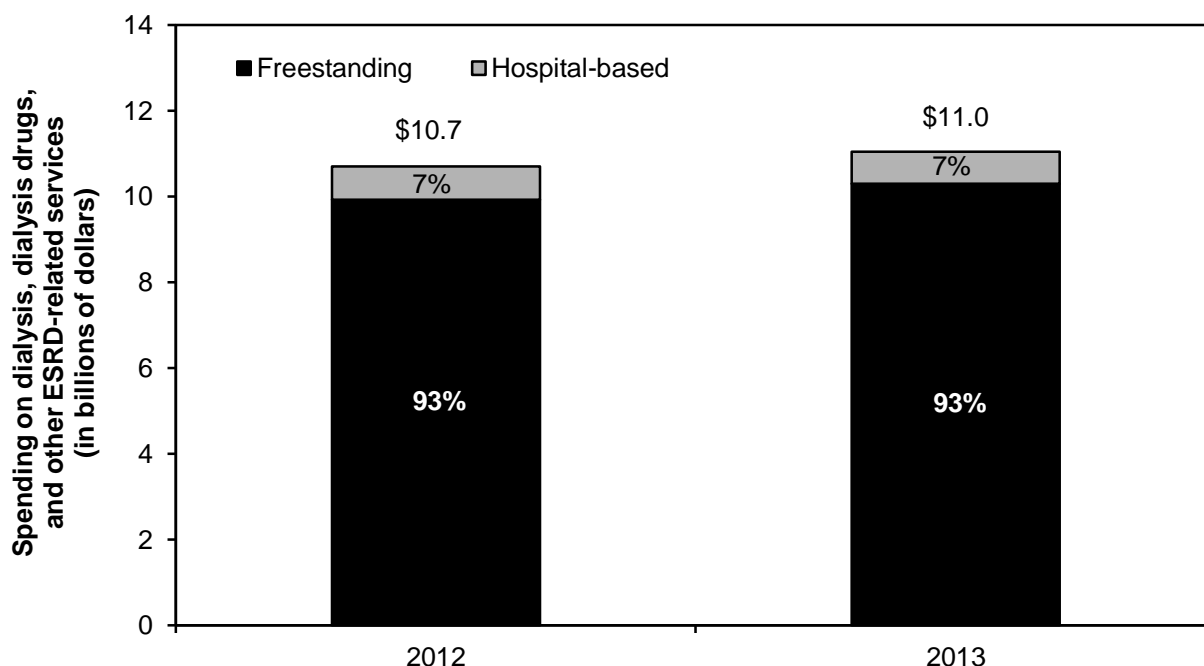
	2014	Average annual percent change	
		2009–2014	2013–2014
Total number of:			
Dialysis facilities	6,298	3%	5%
Hemodialysis stations	110,676	3	4
Mean number of hemodialysis stations per facility	18	0.1	–0.8
	Percent of total		
Hospital-based	7%	–5	–5
Freestanding	93	4	6
Urban	80	4	5
Rural, micropolitan	13	1	3
Rural, adjacent to urban	5	2	0
Rural, not adjacent to urban	3	2	3
Frontier	1	0.5	6
For profit	87	4	6
Nonprofit	13	–3	–2

Note: “Nonprofit” includes facilities designated as either nonprofit or government. “Average annual percent change” is based on comparing 2009, 2013, and 2014 end-of-year files.

Source: Compiled by MedPAC from the 2009, 2013, and 2014 CMS Dialysis Compare end-of-year files.

- Between 2009 and 2014, the number of freestanding and for-profit facilities increased, while hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 89 percent to 93 percent of all facilities, and for-profit facilities increased from 82 percent to 87 percent of all facilities.
- Between 2009 and 2014, the proportion of facilities located in rural areas has remained relatively constant.
- Since 2009, the number of facilities has increased 3 percent per year. The average size of a facility has remained relatively constant, averaging about 18 dialysis treatment stations per facility (17.4 stations in 2009, 17.7 stations in 2013, and 17.6 stations in 2014).

Chart 11-2. Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2012 and 2013



Note: ESRD (end-stage renal disease).

Source: Compiled by MedPAC from the 2012 and 2013 institutional outpatient files from CMS.

- In 2013, total spending for dialysis, dialysis drugs, and ESRD-related clinical laboratory tests was \$11.0 billion. In 2013, Medicare paid nearly all facilities under a modernized prospective payment system that includes in the payment bundle certain dialysis drugs and ESRD-related clinical laboratory tests that were separately paid before 2011.
- Between 2012 and 2013, total ESRD expenditures increased by about 3 percent.
- Freestanding dialysis facilities treat most dialysis beneficiaries and accounted for 93 percent of expenditures in 2012 and 2013.

Chart 11-3. The ESRD population is growing, and most ESRD patients undergo dialysis

	2002		2008		2012	
	Patients (thousands)	Percent	Patients (thousands)	Percent	Patients (thousands)	Percent
Total	431.0	100%	548.9	100%	636.9	100%
Dialysis	313.0	73	388.6	71	450.6	71
In-center hemodialysis	282.2	65	353.2	64	400.8	63
Home hemodialysis*	1.6	0.4	4.5	0.8	7.9	1.2
Peritoneal dialysis*	28.4	7	29.7	5	40.7	6
Unknown	0.8	0.2	1.2	0.2	1.2	0.2
Functioning graft and kidney transplants	118.1	27	160.2	29	186.3	29

Note: ESRD (end-stage renal disease). Totals may not equal sum of components due to rounding. Data include both Medicare and non-Medicare patients.
* Home dialysis methods.

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with ESRD require either dialysis or a kidney transplant to maintain life. The total number of ESRD patients increased by 4 percent annually between 2002 and 2012.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is the most common form of home dialysis.
- Most ESRD patients undergo hemodialysis administered in a dialysis facility three times a week. Between 2002 and 2012, the total number of in-center hemodialysis patients and peritoneal dialysis patients each increased by 4 percent annually. Although a smaller proportion of all dialysis patients undergo home hemodialysis, the number of these patients grew 18 percent per year during this time period.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living kidney or a cadaveric kidney donation. In 2012, 32 percent of transplanted kidneys were from living donors and the remainder were from cadaver donors.

Chart 11-4. Asian Americans and Hispanics are among the fastest growing segments of the ESRD population

	Percent of total in 2012	Average annual percent change 2007–2012
Total (<i>n</i> = 636,905)	100%	4%
Age (years)		
0–19	1	–0.2
20–44	16	1
45–64	44	4
65–79	30	5
80+	9	5
Sex		
Male	57	4
Female	43	3
Race/ethnicity		
White	60	4
African American	32	4
Native American	1	3
Asian American	6	7
Hispanic	17	6
Non-Hispanic	83	3
Underlying cause of ESRD		
Diabetes	38	4
Hypertension	25	4
Glomerulonephritis	17	2
Other causes	21	4

Note: ESRD (end-stage renal disease). Totals may not equal sum of the components due to rounding. ESRD patients include those who undergo maintenance dialysis and those who have a functioning kidney transplant.

Source: Compiled by MedPAC from the United States Renal Data System.

- Among ESRD patients, 39 percent are over age 65. About 60 percent are White.
- Diabetes is the most common cause of renal failure.
- The number of ESRD patients increased by 4 percent annually between 2007 and 2012. Among the fastest growing groups of patients are Asian Americans and Hispanics.

Chart 11-5. Characteristics of Medicare fee-for-service dialysis patients, 2013

		Percent of all FFS dialysis patients
Age (years)		
	Under 45	12%
	45–64	38
	65–74	26
	75–84	18
	85+	7
Sex		
	Male	55
	Female	45
Race		
	White	49
	African American	36
	All other	15
Residence		
	Urban county	82
	Rural county, micropolitan	11
	Rural county, adjacent to urban	5
	Rural county, not adjacent to urban	3
	Frontier county	1
Prescription drug coverage status		
	Enrolled in Part D plan or other source of creditable drug coverage	85
	LIS	58
Dually eligible for Medicare and Medicaid		48

Note: FFS (fee-for-service), LIS (low-income [drug] subsidy). Urban counties contain a core area with 50,000 or more people, rural micropolitan counties contain at least one cluster of at least 10,000 and less than 50,000 people, rural counties adjacent to urban areas do not have a city of 10,000 people in the county, and rural counties not adjacent to urban areas do not have a city of 10,000 people. Frontier counties are counties with six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of dialysis claims files and denominator files from CMS.

- Compared with all Medicare patients, FFS dialysis patients are disproportionately younger and African American.
- In 2013, nearly 20 percent of FFS dialysis patients resided in a rural county.
- Nearly half of all dialysis patients were dually eligible for Medicare and Medicaid services.
- About 85 percent of FFS dialysis patients were enrolled in Part D plans or had other sources of creditable drug coverage.

Chart 11-6. Aggregate margins vary by type of freestanding dialysis facility, 2013

Type of facility	Percentage of freestanding facilities	Aggregate margin
All facilities	100%	4.3%
Urban	80	4.9
Rural	20	0.6
LDOs	77	4.1
Non-LDOs	23	5.2
Treatment volume (quintile)		
Lowest	20	-12.3
Second	20	-3.8
Third	20	2.0
Fourth	20	6.0
Highest	20	9.7

Note: LDO (large dialysis organization). Margins include payments and costs for composite rate services, injectable drugs, and other end-stage renal disease–related services.

Source: Compiled by MedPAC from 2013 cost reports and the 2013 institutional outpatient file from CMS.

- For 2013, the aggregate Medicare margin for composite rate services and injectable drugs was 4.3 percent.
- Generally, freestanding dialysis facilities' margins vary by the size of the facility; facilities with greater treatment volume have higher margins on average. Differences in capacity and treatment volume explain some of the differences observed between the margins of urban and rural facilities. Urban facilities are larger on average than rural facilities with respect to the number of dialysis treatment stations and Medicare treatments provided. Some rural facilities have benefited from the low-volume adjustment that is included in the new end-stage renal disease payment method that began in 2011.

Chart 11-7. Medicare hospice spending and average length of stay were virtually unchanged in 2013

	2000	2012	2013	Average annual change, 2000–2012	Change, 2012–2013
Beneficiaries in hospice (in millions)	0.534	1.274	1.315	7.5%	3.2%
Medicare payments (in billions)	\$2.9	\$15.1	\$15.1	14.7%	–0.1%
Average length of stay among decedents (in days)	53.5	88.0	87.8	4.2%	–0.2%
Median length of stay among decedents (in days)	17	18	17	+1 day*	–1 day

Note: Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. Due to rounding, the percent change displayed in the chart may not equal the percent change calculated using the yearly data displayed in the chart.

* This figure reflects the raw change between 2000 and 2013, rather than the percent change.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims standard analytic file from CMS.

- The number of Medicare beneficiaries receiving hospice services more than doubled between 2000 and 2012 and continued to grow in 2013, suggesting that access to hospice care has increased.
- Average length of stay held steady at about 88 days between 2012 and 2013, after a long period of growth.
- Total Medicare payments to hospices were about \$15.1 billion in 2013, about the same as 2012. The flat spending between 2012 and 2013 partly reflects the effect of the sequester, which reduced Medicare payments by 2 percent beginning April 1, 2013.

Chart 11-8. Hospice use increased across beneficiary groups from 2000 to 2013

	Share of decedents using hospice			Average annual percentage point change 2000–2012	Percentage point change 2012–2013
	2000	2012	2013		
All	22.9%	46.7%	47.3%	2.0%	0.6%
FFS beneficiaries	21.5	45.7	46.2	2.0	0.5
MA beneficiaries	30.9	50.4	50.6	1.6	0.2
Dual eligibles	17.5	41.6	42.1	2.0	0.5
Non–dual eligibles	24.5	48.4	48.9	2.0	0.5
Age (years)					
<65	17.0	29.2	29.2	1.0	0.0
65–84	24.7	45.0	45.3	1.7	0.3
85+	21.4	54.0	55.0	2.7	1.0
Race/ethnicity					
White	23.8	48.6	49.2	2.1	0.6
Minority	17.3	36.5	37.0	1.6	0.5
Gender					
Male	22.4	42.8	43.3	1.7	0.5
Female	23.3	50.2	50.9	2.2	0.7
Beneficiary location					
Urban	24.3	48.0	48.5	2.0	0.5
Micropolitan	18.5	43.4	44.3	2.1	0.9
Rural, adjacent to urban	17.6	42.2	42.9	2.1	0.7
Rural, nonadjacent to urban	15.8	37.7	38.0	1.8	0.3
Frontier	13.2	31.9	32.2	1.6	0.3

Note: FFS (fee-for-service), MA (Medicare Advantage). “Beneficiary location” refers to the beneficiary’s county of residence. Urban, micropolitan, and rural designations are based on the urban influence codes. The frontier category is defined as population density equal to or less than six persons per square mile.

Source: MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

- Hospice use grew in almost all beneficiary groups in 2013, continuing the trend of a growing proportion of beneficiaries using hospice at the end of life.
- Despite this growth, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, MA enrollees, not dual eligible, or living in an urban area were more likely to use hospice than their counterparts.

Chart 11-9. Number of Medicare-participating hospices has increased due to growth in for-profit hospices

	2000	2011	2012	2013
All hospices	2,255	3,585	3,727	3,925
For profit	672	2,054	2,199	2,411
Nonprofit	1,324	1,314	1,318	1,314
Government	257	217	209	200
Freestanding	1,069	2,491	2,643	2,844
Hospital based	785	587	568	553
Home health based	378	486	492	503
SNF based	22	21	23	25
Urban	1,424	2,536	2,670	2,824
Rural	788	986	983	978

Note: SNF (skilled nursing facility). Numbers may not sum to totals because of missing data for a small number of providers.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and the standard analytic file of hospice claims from CMS.

- There were more than 3,900 Medicare-participating hospices in 2013. Most of them were for-profit hospices.
- Between 2000 and 2013, the number of Medicare-participating hospices grew by nearly 1,700 providers. For-profit hospices accounted almost entirely for that growth.
- Growth in the number of providers has occurred predominantly among freestanding and home health–based providers. The number of hospital-based providers has declined.
- The number of hospices in rural and urban areas was substantially higher in 2013 than in 2000, although the number of hospices in rural areas declined modestly in the past few years. The share of hospices located in rural areas (26 percent) and urban areas (74 percent) is similar to the share of Medicare beneficiaries residing in these two types of areas.

Chart 11-10. Hospice cases and length of stay, by diagnosis, 2013

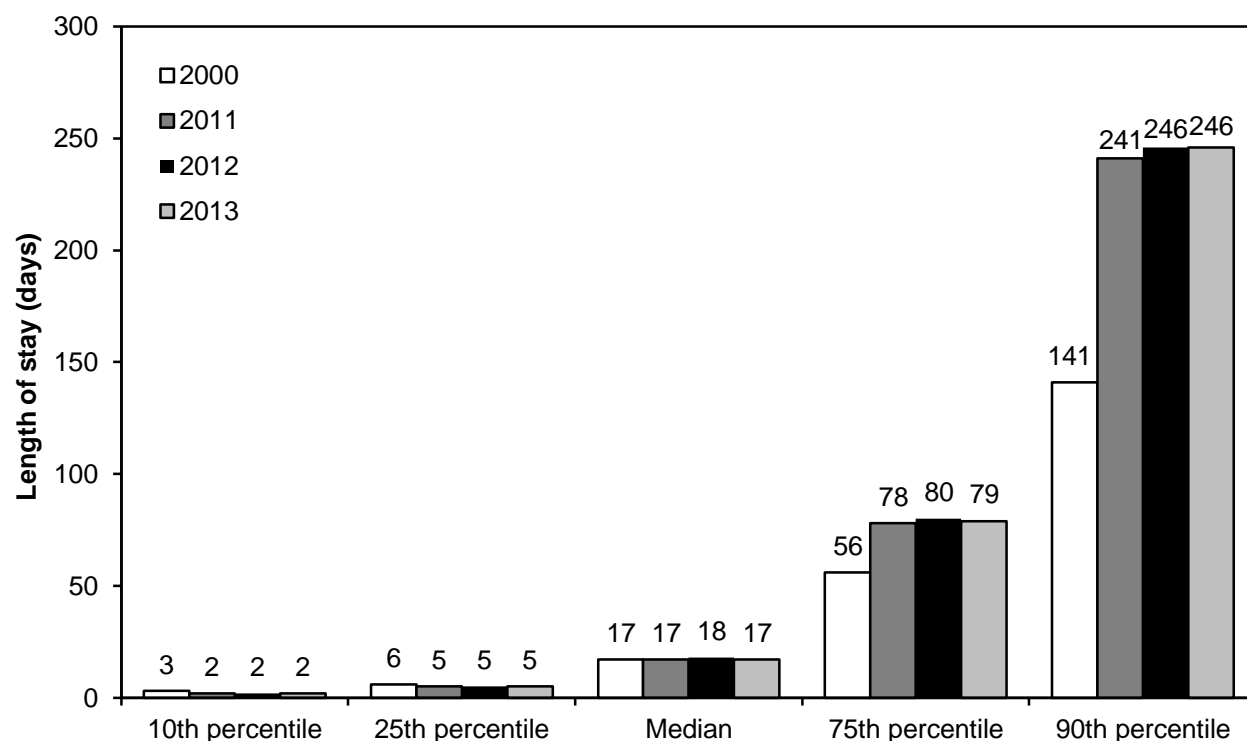
Diagnosis	Share of total cases	Percent of cases with length of stay greater than 180 days
Cancer (except lung cancer)	21%	10%
Circulatory, except heart failure	13	22
Heart failure	9	22
Alzheimer's and similar diseases	8	38
Lung cancer	8	9
Organic psychoses	6	32
Chronic airway obstruction, NOS	6	28
Dementia	6	35
Debility, NOS	5	26
Respiratory disease	4	13
Adult failure to thrive	4	25
Nervous system, except Alzheimer's	3	33
Genitourinary disease	3	7
Other	2	12
Digestive disease	2	9
All	100	21

Note: NOS (not otherwise specified). Cases include all patients who received hospice care in 2013, not just decedents. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file from CMS and the Medicare Beneficiary Database.

- In 2013, the most common terminal diagnosis among Medicare hospice patients was cancer (all types), accounting for about 29 percent of cases. The next most common diagnoses were Alzheimer's disease, dementia, organic psychoses, and other neurological conditions (23 percent of cases), and heart failure and other circulatory conditions (22 percent of cases).
- Length of stay varies by diagnosis. Nearly one-quarter or more of hospice patients in 2013 with Alzheimer's disease, dementia, nervous system disorders, organic psychoses, chronic airway obstruction, debility, and adult failure to thrive had lengths of stay exceeding 180 days. Long hospice stays were least common among beneficiaries with genitourinary disease, digestive disease, and cancer.

Chart 11-11. Hospice length of stay changed little in 2013, after a more than decade-long period of growth in the longest stays



Note: Data reflect hospice length of stay for Medicare decedents who used hospice at the time of death or before death. "Length of stay" reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime.

Source: MedPAC analysis of the denominator file and the Medicare Beneficiary Database from CMS.

- In 2013, the 10 percent of hospice decedents with the longest stays (i.e., the 90th percentile) received 246 days or more of hospice care, unchanged from 2012. Before 2013, most growth in hospice length of stay occurred among decedents with the longest stays. Between 2000 and 2012, the 90th percentile in length of stay grew from 141 days to 246 days.
- Short stays in hospice have changed little since 2000. The median length of stay in hospice was 17 days in 2013 and has held steady at 17 or 18 days since 2000. Hospice length of stay at the 25th percentile has remained at five or six days since 2000.

Chart 11-12. Hospice length of stay among decedents, by beneficiary and hospice characteristics, 2013

	Average length of stay (in days)	Length of stay percentiles (in days)		
		10th	50th	90th
Beneficiary				
Diagnosis				
Cancer	53	3	18	129
Neurological	147	3	31	443
Heart/circulatory	81	2	12	236
Debility or adult failure to thrive	116	3	32	336
COPD	113	2	22	335
Other	42	2	6	103
Site of service				
Home	89	4	26	237
Nursing facility	111	3	21	331
Assisted living facility	152	5	51	435
Hospice				
For profit	105	3	21	306
Nonprofit	68	2	14	183
Freestanding	91	2	17	257
Home health based	68	2	15	187
Hospital based	59	2	13	158

Note: COPD (chronic obstructive pulmonary disease). Average length of stay is calculated for Medicare beneficiaries who died in 2013 and used hospice that year, and it reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data, Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file data from CMS.

- Hospice average length of stay among decedents varies by both beneficiary and provider characteristics. Most of this variation reflects differences in length of stay among patients with the longest stays (i.e., at the 90th percentile). Length of stay varies much less for patients with shorter stays (i.e., at the 10th or 50th percentile).
- Beneficiaries with neurological conditions, COPD, or debility or adult failure to thrive have the longest stays, while beneficiaries with cancer have the shortest stays on average.
- Beneficiaries who receive hospice services in assisted living facilities and nursing facilities have longer stays on average than beneficiaries who receive care at home or in a hospice facility or hospital.
- For-profit and freestanding hospices have longer average lengths of stay than nonprofit and provider-based hospices.

Chart 11-13. More than half of Medicare hospice spending in 2013 was for patients with stays exceeding 180 days

	Medicare hospice spending, 2013 (in billions)
All hospice users in 2013	\$15.1
Beneficiaries with LOS > 180 days	8.8
Days 1–180	2.9
Days 181–365	2.8
Days 366+	3.1
Beneficiaries with LOS ≤ 180 days	6.2

Note: LOS (length of stay). LOS reflects the beneficiary's lifetime LOS as of the end of 2013 (or at the time of discharge in 2013 if the beneficiary was not enrolled in hospice at the end of 2013). All spending reflected in the chart occurred only in 2013. Break-out groups do not sum to total because they exclude about \$0.1 billion in payments to hospices for physician visits.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data and the common Medicare enrollment file from CMS.

- In 2013, Medicare hospice spending on patients with stays exceeding 180 days was nearly \$9 billion, more than half of all Medicare hospice spending that year.
- About \$3.1 billion, or about 20 percent, of Medicare hospice spending in 2013 was on additional hospice care for patients who had already received at least one year of hospice.

Chart 11-14. Hospice aggregate Medicare margins, 2006–2012

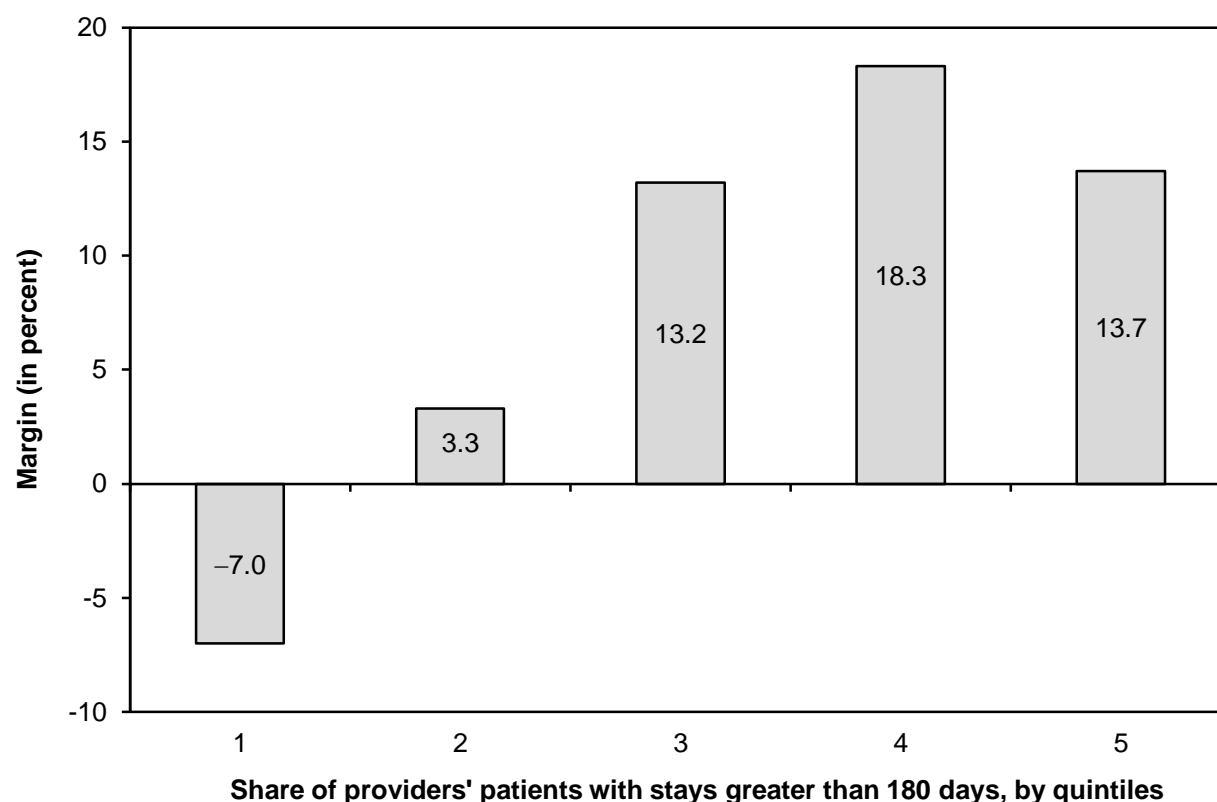
	Share of hospices (2012)	Medicare margin				
		2006	2009	2010	2011	2012
All	100%	6.4%	7.4%	7.4%	8.8%	10.1%
Freestanding	71	9.7	10.2	10.7	11.8	13.3
Home health based	13	3.8	5.9	3.2	6.1	5.5
Hospital based	15	–12.7	–12.2	–16.6	–16.0	–16.8
For profit	59	12.0	11.7	12.3	14.8	15.4
Nonprofit	35	1.5	3.8	3.0	2.4	3.7
Government	6	N/A	N/A	N/A	N/A	N/A
Urban	73	7.1	7.9	7.7	9.1	10.3
Rural	27	0.8	3.7	5.2	6.0	7.8
Below cap	89	7.0	7.9	7.7	9.1	10.4
Above cap	11	0.3	1.4	3.2	4.1	5.2
Above cap (including cap overpayments)	11	20.7	18.3	17.4	18.4	21.3

Note: N/A (not available). Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. Percent of freestanding and provider-based (home health–based and hospital-based) hospices does not sum to 100 percent because skilled nursing facility–based hospices are not broken out separately. Percent of hospices may not sum to 100 percent for other categories due to rounding.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims standard analytic file, and Medicare Provider of Services data from CMS.

- The aggregate Medicare margin was 10.1 percent in 2012, up from 8.8 percent in 2011.
- Margin estimates do not include nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.4 and 0.3 percentage points, respectively). Margins also do not include the costs and revenues associated with fundraising.
- Freestanding hospices had higher margins than provider-based (home health– and hospital-based) hospices, in part, because of differences in their indirect costs. Provider-based hospices' indirect costs are higher than those of freestanding providers and are likely inflated because of the allocation of overhead from the parent provider.
- In 2012, for-profit hospice margins were strong at 15.4 percent. The aggregate margin for nonprofit hospices was 3.7 percent. The subset of nonprofit hospices that were freestanding had a higher margin, 7.7 percent (not shown in chart).
- Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a margin of more than 21 percent before the return of the cap overpayments.

Chart 11-15. Medicare margins are higher among hospices with more long stays, 2012



Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims standard analytic file from CMS.

- Medicare's per diem payment system for hospice provides an incentive for longer lengths of stay.
- Hospices with more patients who had stays greater than 180 days generally have higher margins. In 2012, hospices in the lowest length-of-stay quintile had a margin of -7.0 percent compared with an 18.3 percent margin for hospices in the second highest length-of-stay quintile.
- Margins were somewhat lower in the highest length-of-stay quintile (13.7 percent) compared with the second highest quintile (18.3 percent) because some hospices in the highest quintile exceeded Medicare's aggregate payment cap and were required to repay the overage. Hospices exceeding the cap had a margin of more than 21 percent before the return of overpayments (see Chart 11-14).

Chart 11-16. Hospices that exceeded Medicare's annual payment cap, selected years

	2002	2009	2010	2011	2012
Share of hospices exceeding the cap	2.6%	12.5%	10.1%	9.8%	11.0%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$470	\$485	\$426	\$424	\$510
Payments over the cap as a percent of overall Medicare hospice spending	0.6%	1.7%	1.1%	1.1%	1.4%

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year. These estimates of hospices that exceeded the aggregate cap are based on the Commission's analyses. While the estimates are intended to approximate those of the Medicare claims-processing contractors, they are not necessarily identical to the contractors' estimates because of differences in available data and methodology.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data, Medicare hospice cost reports, Provider of Services file data from CMS, and CMS Providing Data Quickly system. Data on total spending for each fiscal year are from the CMS Office of the Actuary.

- The share of hospices exceeding the aggregate cap increased from 9.8 percent in 2011 to 11 percent in 2012, reversing the trend seen since 2009 of a declining share of hospices exceeding the cap.
- Medicare payments over the cap represented 1.4 percent of total Medicare hospice spending in 2012.
- On average, above-cap hospices exceeded the cap by about \$510,000 per provider in 2012, the highest amount since 2006.

Chart 11-17. Length-of-stay and live-discharge rates for above- and below-cap hospices, 2012

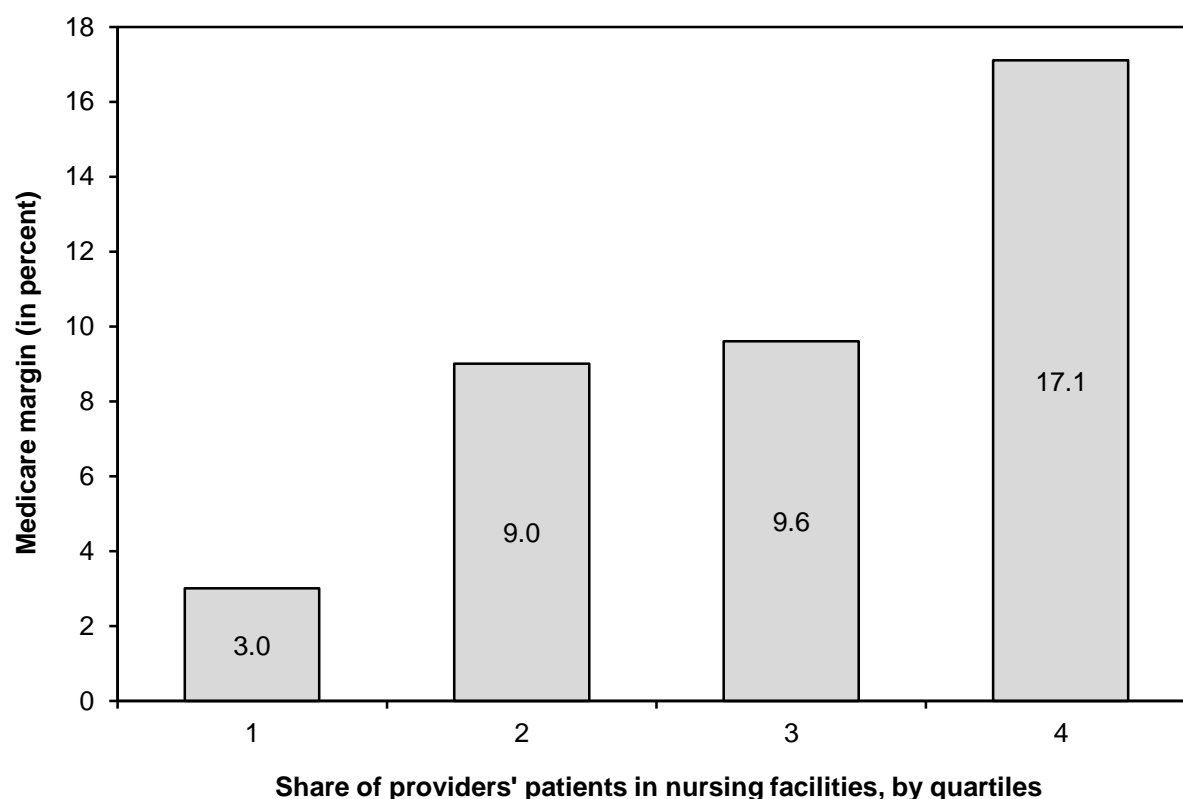
Diagnosis	Share of hospice users with stays exceeding 180 days		Live discharges as a percent of all discharges	
	Above-cap hospices	Below-cap hospices	Above-cap hospices	Below-cap hospices
All	42%	20%	40%	16%
Cancer	18	9	24	11
Neurological conditions	53	33	39	20
Heart/circulatory	45	20	48	17
Debility or adult failure to thrive	42	26	47	23
COPD	46	27	49	22
Other	29	9	36	11

Note: COPD (chronic obstructive pulmonary disease). Length-of-stay data reflect the share of hospice users in 2012 whose hospice length of stay was beyond 180 days. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file and denominator file from CMS.

- Above-cap hospices have substantially more patients with very long stays and more live discharges than below-cap hospices for all diagnoses.
- In 2012, between 42 percent and 53 percent of above-cap hospices' patients with neurological conditions, heart or circulatory conditions, COPD, or debility or adult failure to thrive had stays exceeding 180 days compared with 20 percent to 33 percent at below-cap hospices.
- For all diagnoses, the live-discharge rates at above-cap hospices were at least roughly double, and in some cases triple, the rates at below-cap hospices. For example, among patients with heart or circulatory conditions, 48 percent of discharges at above-cap hospices were live discharges compared with 17 percent at below-cap hospices.

Chart 11-18. Margins are higher among hospices with a greater share of their patients in nursing facilities, 2012

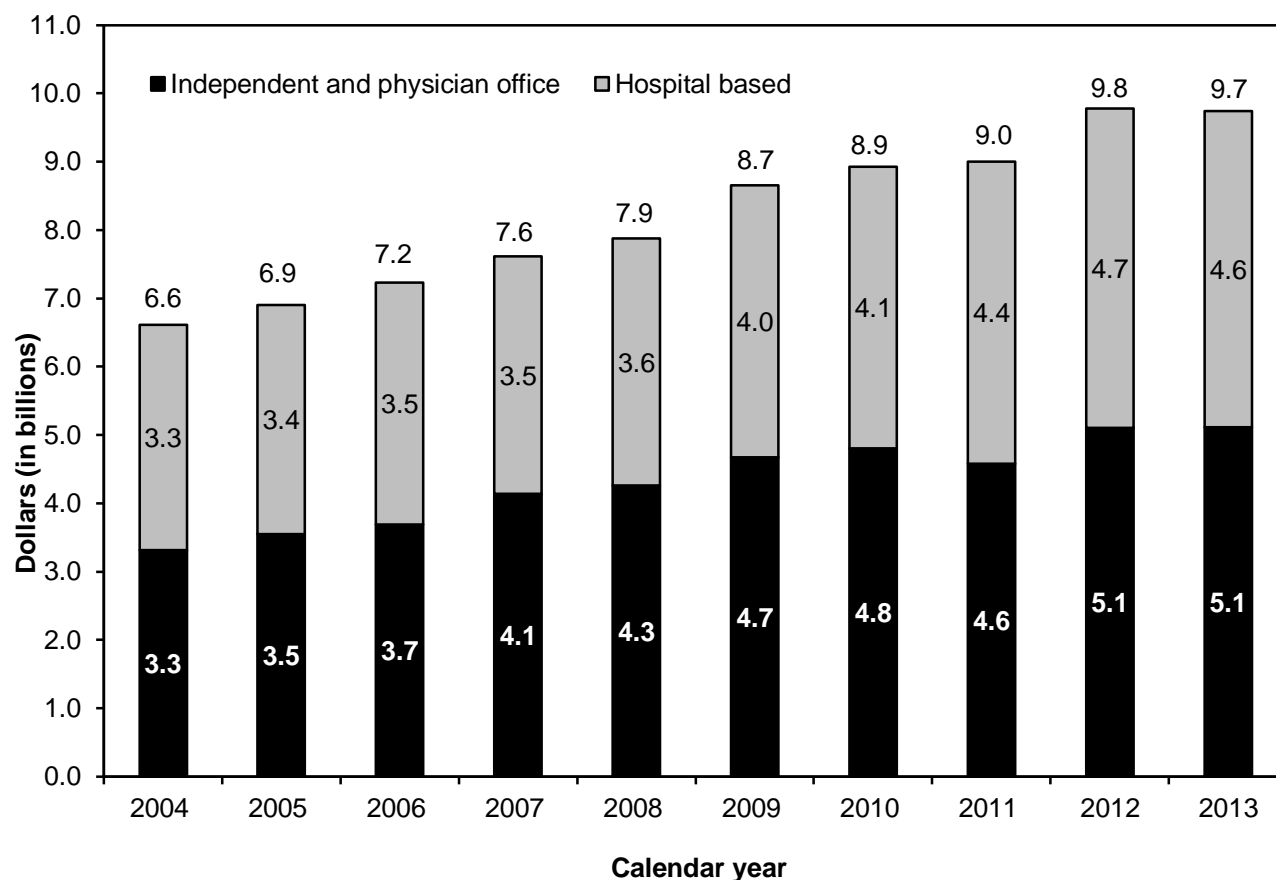


Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims standard analytic file from CMS.

- Hospices with a large share of their patients in nursing facilities have higher margins than other hospices.
- The higher profitability of hospices serving many nursing facility patients may be due to a combination of factors, such as longer lengths of stay, possible efficiencies in treating patients in a centralized location (e.g., lower mileage costs and less staff time for travel), and overlap in responsibilities between the hospice and the nursing facility.

Chart 11-19. Medicare spending for clinical laboratory services, 2004–2013



Note: Spending is for services paid under the clinical laboratory fee schedule. Hospital-based services are furnished in labs owned or operated by hospitals. Total spending appears on top of each bar. The spending data include only program payments; there is no beneficiary cost sharing for clinical lab services.

Source: AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2015. THIS CHART REFLECTS DATA FROM THE 2014 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2015 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.

- Medicare spending for clinical laboratory services grew by an average of 4.4 percent per year between 2004 and 2013. This growth was primarily driven by rising volume since there were very few increases in payment rates during those years.
- Medicare spending for lab services in all settings increased by 8.6 percent in 2012 but held steady in 2013. Clinical lab services accounted for 1.7 percent of total Medicare spending in 2013.
- In 2013, independent and physician-office labs accounted for 52 percent of Medicare spending for all lab services; hospital-based labs accounted for the remaining 48 percent.

